

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-020371

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 2754

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED MAY 29 1963

VS 300	DATE AMENDED	AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF	DOCUMENT
Rev. 4/59			
1			
2 <u>06602</u>			
3			
4 <u>0</u>			
5 <u>0</u>			
6			
7 <u>0</u>			
8 <u>1</u>			
9 <u>5401</u>			
10			
11			
12 <u>64-0</u>			
13			
	BY AFFIDAVIT OF		

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Miller	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		Length of stay in 1b 7 Days	c. CITY OR TOWN Eldon Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Research Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Route 2 Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Le ROY Middle C. Last WELSH			4. DATE OF DEATH Month May Day 11 Year 1963
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 2-16-1892
9. AGE (last birthday) 71		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Postal Clerk		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Laclede, Missouri
12. CITIZEN OF WHAT COUNTRY U. S. A.		13a. FATHER'S NAME Cassius S. Welsh	
13b. MOTHER'S MAIDEN NAME Irene F. Allen		14. NAME OF HUSBAND OR WIFE - - -	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates) W. W. I		16. SOCIAL SECURITY NO.	17. INFORMANT Roscoe S. Welsh Address Eldon, Missouri
18. CAUSE OF DEATH (Enter only one cause per item 18. (a) through (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Peritonitis DUE TO (b) Perforated pyloric gastric ulcer DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH 9 days 9 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION	COUNTY STATE
21. I attended the deceased from 4 May 63 to 11 May 63 and last saw him alive on 11 May 63 Death occurred at 2:45 P on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE John B. Willoughby M.D. (Degree or title)		22b. ADDRESS 6400 Prospect K.C. Mo	22c. DATE SIGNED 12 May 63
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 5-12-63	23c. NAME OF CEMETERY OR CREMATORY Laclede Cemetery	23d. LOCATION (City, town, or county) (State) Laclede, Missouri
24. FUNERAL DIRECTOR Freeman Mortuary ADDRESS Kansas City, Mo.		25. DATE RECD. BY LOCAL-REG. 5-12-63	26. REGISTRAR'S SIGNATURE Ruth Long

USE BLACK INK OR TYPEWRITER RIBBON

JAN 30 1964

JUN 3 1963

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed J. R. Freeman

Licensed Embalmer No. 2939

P. O. Address F. O. W. O.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.